PRINTED: 07/31/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS436AGC 07/28/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3980 PLACITA AVENUE QUALITY GUEST HOME 2** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 Y 000 **Initial Comments** The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 7/28/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for five Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness Category I residents. The census at the time of the survey was four. Four resident files were reviewed and three employee files were reviewed. three discharged resident files were reviewed. The facility received a grade of D. The following deficiencies were identified: Y 072 Y 072 449.196(3) Qualications of Caregiver-Med SS=F Training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training

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chapter 441A of NAC for the employee.

This Regulation is not met as evidenced by: Based on record review on 7/28/09, the facility failed to ensure 1 of 3 employees complied with NAC 441A.375 regarding tuberculosis testing

Bureau of Health Care Quality & Compliance

AND DUAN OF CODDECTION 1 '		, ,	) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
NVS436AGC			B. WING		07/28/2009			
NAME OF PR	OVIDER OR SUPPLIER	11101001100	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	0772	5/2000	
QUALITY GUEST HOME 2				80 PLACITA AVENUE S VEGAS, NV 89121				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CTION SHOULD BE O THE APPROPRIATE		
Y 103	Continued From page	2		Y 103				
	Employee #2 did not TB test, or an annual	e protection of all reside have evidence of a two TB test for this year. ficiency from the 9/11/0	-step					
	State Licensure survey.							
	Severity: 2 Scope: 3	3						
Y 151 SS=C	449.204(1)(b) Insurar	nce		Y 151				
	against liability to third appropriate for the pro	ct of insurance for proted persons in amounts						
	Based on interview are the facility failed to main insurance for the facil	ity on site. Interview w d the insurance policy w	/09, ith					
	This was a repeat def State Licensure surve	ficiency from the 9/11/0	8					
	Severity: 1 Scope: 3							
Y 175 SS=F	449.209(4)(b) Health	and Sanitation-Hazard	s	Y 175				
	NAC 449.209 4. To the extent pract facility must be kept fi	icable, the premises of ree from:	the					

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

failed to ensure the interior premises was well maintained. Linoleum in the kitchen, living room, hallway and bedrooms was pulling away from the wall, and portions were missing. The toilet seat cover in Bathroom #1 was missing, there was mold in the shower in Bathroom #1 and the sliding glass door used for the shower was hard to open. The shower in Bathroom #2 had paint

chipping away.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NVS436AGC

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

3980 PLACITA AVENUE

(X2) MULTIPLE CONSTRUCTION

A. BUILDING
B. WING

07/28/2009

0	OVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE				
QUALITY GUEST HOME 2		3980 PLACITA AVENUE LAS VEGAS, NV 89121				
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Y 178	Continued From page 4	Y 178	3			
	Severity: 2 Scope: 3					
Y 179 SS=E	449.209(6) Health and Sanitation-Screens	Y 179	9			
	NAC 449.209 6. All windows that are capable of being ope in the facility and all doors that are left open provide ventilation for the facility must be screened to prevent the entry of insects.					
	This Regulation is not met as evidenced by: Based on observation on 7/28/09, the facility failed to provide screens doors on all of the windows to prevent the entry of insects. (The windows were missing screens. The window the family room on the same wall as the front door, the widow in the kitchen that opened in the laundry room, and the widow in the caregiver's bedroom next to the tall gray filling cabinet.)	ree v in t				
	Severity: 2 Scope: 3					
Y 223 SS=F	449.213(3) Laundry-Linen - Equipment, Ven	ting Y 223	3			
	NAC 449.213 3. The laundry room in a residential facility me be situated in an area which is separate from area where food is stored, prepared or served The laundry must be adequate in size for the needs of the facility and maintained in a sammanner. The laundry room must contain at lone washer and at least one dryer. All the equipment must be kept in good repair.	n an ed. e itary				

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Y 251

Based on interview and observation on 7/28/09, the facility failed to ensure 1 of 1 dryers was working properly and vented to the outside of the building. The surveyor turned on the dryer and it made a noise at which time Employee #2 stated the dryer was not working properly.

Severity: 2 Scope: 3

Y 251 SS=F 449.217(2) Storage of Food-Perishable foods refrigerated

NAC 449.217

2. Perishable foods must be refrigerated at a temperature of 40 degrees Fahrenheit or less. Frozen foods must be kept at a temperature of 0 degrees or less.

This Regulation is not met as evidenced by: Based on observation on 7/28/09, the facility failed to ensure refrigerated foods were kept at a temperature of 40 degrees or less, and frozen foods were kept at a temperature of 0 degrees or less.

Severity: 2 Scope: 3

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Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING \_ NVS436AGC

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER  QUALITY GUEST HOME 2		3980 PLACITA AVENUE LAS VEGAS, NV 89121				
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Y 859 Continued From page 7		Y 859	9			
Y 859 SS=E	· · · · · · · · · · · · · · · · · · ·		9			
	NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition or resident, the facility shall obtain the results or general physical examination of the resident his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician.	f a by				
	This Regulation is not met as evidenced by: Based on record review on 7/28/09, the facil failed to ensure that 3 of 7 residents received annual physical (Resident #1, #2 and #5). Resident #1 was admitted 5/1/09, the only physical in the file was dated 4/3/07. Resident was admitted 7/2/08, the only physical in the was dated 10/14/08. Resident #5 was admit 12/5/08, no evidence of a physical was in the This was a repeat deficiency from the 9/11/0	ent #2 file tted e file.				
	State Licensure survey.					
	Severity: 2 Scope: 2					
Y 878 SS=I	449.2742(6)(a)(1) Medication / Change orde	r Y 878	3			
f deficiencia	NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a are cited, an approved plan of correction must be returne	d within 10 days after	againt of this statement of deficiencies			

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS436AGC 07/28/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3980 PLACITA AVENUE QUALITY GUEST HOME 2** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 878 Continued From page 8 Y 878 physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on record review and interview on 7/28/09, the facility failed to ensure that 3 of 4 residents received medications as prescribed (Resident #1, #2 and #3). This was a repeat deficiency from the 9/11/08 State Licensure survey. Findings include: Resident #2 - Clonazepam .5 MG two tablets by mouth in the morning. The resident did not receive the medication from 7/1/09 through 7/7/09. Resident #2 was able to tell the surveyor she was prescribed Clonazepam for anxiety, and the facility ran out of the medication during the beginning of July. Resident #2 stated the facility tried to contact the pharmacy regarding the medication, but did not receive a response. Resident #2 went to the doctor 7/7/09 for a TB test, and while in the clinic asked the doctor about her prescription for Clonazepam. The doctor failed to submit the prescription to the pharmacy. Resident #2 states during the first week of July she was anxious and on two occasions unable to

leave the facility due to anxiety.

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This Regulation is not met as evidenced by: Based on observation on 7/28/09, the facility failed to ensure a physician was notified for 3 of 3

residents who missed medications.

Severity: 3 Scope: 3

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NAC 449.2744

1. The administrator of a residential facility that

provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered to each resident. The record must include:

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SS=F

NAC 449.2748

3. Medication, including, without limitation, any

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

NVS436AGC

NAME OF PROVIDER OR SUPPLIER

OUALITY GUEST HOME 2

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

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STREET ADDRESS, CITY, STATE, ZIP CODE

3980 PLACITA AVENUE

QUALITY GUEST HOME 2		3980 PLACITA AVENUE LAS VEGAS, NV 89121			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMAT	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
Y 923	Continued From page 12 over-the-counter medication or dietary supplement, must be: (b) Kept in its original container until it is administered.		Y 923		
	This Regulation is not met as evidenced by Based on observation on 7/28/09, the facility failed to keep medications belonging to 4 of residents in their original container (Residen #2, #3 and #4).  Severity: 2 Scope: 3	y 4			
Y 944 SS=A	449.2749(2) Resident File / Discharge		Y 944		
	NAC 449.2749 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death.				
	This Regulation is not met as evidenced by Based on record review and interview on 7/2				

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